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1996

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Dedication

I would like to dedicate my thesis to my husband, Chio, Yan-Chuan, who took full responsibility to take care our baby.

Acknowledgements

The author wish to acknowledge the following persons for their assistance with this study: Nancy Stotts; Virginia Carrieri-Kohlman and Patrica Larson, University of California, San Francisco, who were professors in pathophysiology department.

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PATIENTS' SATISFACTION WITH NURSE CARING BEHAVIORS IN THE EMERGENCY DEPARTMENT IN TAIWAN

Caring has been considered the "core" or the "essence" of nursing (Leininger, 1981; Watson, 1979) and is essential to the provision of high quality nursing care (Valentine, 1991). The literature suggests the importance of nursing care systems that satisfy patients by meeting their individual needs from the patient's point of view (Allanach & Golden, 1988; Lucas, Morries, & Alexander, 1988).

The scientifically based knowledge of caring is limited. Only a small number of studies have been conducted on the concept of caring. A critical first step in addressing the concept of caring, as it relates to nursing, is to understand patients' perceptions of what behaviors constitute nurse caring from the perception of the patient. Larson contributed meaningful work to the area when she conducted a series of caring research studies about patients' perceptions of the most important nurse caring behaviors (1984, 1986, 1987, 1991). She defined caring as "intentional actions that convey physical care and emotional concern and promote a sense of safeness and security in another" (Larson, 1993, p. 690). Larson proposed that nurses convey caring so that patients feel safe and secure.

In the current health care environment where cost containment has limited the number of professionals providing care to patients, it is essential to identify and /or verify behaviors of nurses that make patients feel they are being cared for. This problem is accentuated in the emergency department (ED) where patients are hospitalized for a brief period of time. The combination of the limited staff contact and short hospitalization make it critical for professional nurses to use their time wisely and enact caring behaviors important to the ED patients. Thus, it is critical to understand what nurse caring behaviors are important in the ED. Knowing the most important caring behaviors as perceived by patients in the busy ED, nurses can begin to meet expectations of caring behaviors important to ED patients. Nurse caring in the ED can be explored by

evaluating patients satisfaction with the caring they receive from nurses during their stay in the ED. This approach has been used in other studies to determine important nurse caring behaviors with medical-surgical patients (Larson & Ferketich, 1993).

In the ED, patients seek medical help and want quick diagnosis and treatment. Yet, problems of long waiting time in EDs are common throughout the world (Nuttall, 1986). Studies have shown that 80% of nurses consider waiting times to be excessive for patients with non-life-threatening conditions (Jones, 1986). Patient waiting times were negatively associated with patient satisfaction, such that the longer the patient waited, the more dissatisfied she/he was (Bailey et al., 1987; Bursch, Beezy & Shaw, 1993). Thus, it is important to understand the relationship between waiting time and ED patient's perception of satisfaction/ dissatisfaction with nurse caring behaviors.

This study examines patient satisfaction/dissatisfaction with nurse caring behaviors in the ED. The relationship between satisfaction and waiting time also will be examined. If it were known how satisfied patients were with nurse caring behaviors and waiting time in the ED, then interventions could emphasize those behaviors that patients identify as producing satisfaction. Areas of dissatisfaction could become the focus of further nurse education and modification of nurse behaviors. In addition, approaches to minimize waiting time might be devised.

Background of the Study

Theoretical Framework

Caring is fundamental to nursing practice. Focusing on patients' perceptions of their care only and not on other aspects of hospital care such as food service or physician care, provides the opportunity for nurses to carefully examine the effect that their practice has on patients.

Landmark work in identify nurse caring behaviors in clinical was completed by Larson. Her work, conducted in four phases, focused on the development, measurement and refinement of theoretically appropriate measures to assess patients impressions of the

nurse caring they experience (Larson & Ferketich, 1993).

Phase 1 focused on identifying nursing behaviors that denote caring to nurses and patients. Two studies, one with 20 patients and one with 8 nurses, identified 69 nurse caring behaviors categorized within six themes of caring: accessible, explains and facilitates, comforts, anticipates, trusting relationship, monitors and follows through (Larson, 1981).

The behaviors and themes of caring identified and refined in Phase 1 were used in Phase 2 to generate the Caring Assessment Instrument (CARE-Q). It measures perceptions of important nurse caring behavior with Q-methodology, which involves a forced-choice approach. The CARE-Q consists of 50 items of nurse caring behavior divided into six subscale (Larson, 1984, 1987). The subscales reflect the six themes of caring identified in Phase 1 and represent the theoretical dimension of nurse caring needed to ensure that the outcome "feeling cared for" in the patient is met (Larson, 1984).

Phase 3 utilized the CARE-Q to compare cancer patients and nurses perceptions of important nurse caring behaviors (Larson, 1984a, 1984b, 1986, 1987). The CARE-Q was used in a series of replication studies (Keane et al., 1987; Mayer, 1987; Komorita et al., 1991; Magold, 1991; von Essen & Sojden, 1991; Smit & Spoelstra, 1991; Schart & Caley, 1993). Comparing patients' and nurses' perceptions of most important caring behaviors from their studies demonstrated that nurses and patients were not in agreement on what constituted important nurse caring behaviors. Patients tended to select nurse caring behaviors that demonstrated competency, i.e., knowing how to give medication and treatment in a timely manner. Nurses in these studies generally selected items reflecting the affective dimension of nurse caring behaviors, i.e., listening, providing comfort.

The items of the CARE-Q in these initial testings appeared to represent the behavioral domains of caring. However, there was also a possibility that the 50 behavioral items were duplicative and/or that the theoretical categorizations were not adequately reflective of the contemporary domains of nurse caring behaviors. Clinically, it

was challenging to patients and busy nurses to respond to 50 behavioral items using a Q-sort approach to rank the nurse caring behaviors from important to unimportant. To address these concerns Phase 4 was undertaken.

In Phase 4, the 50 items of the CARE-Q were reformatted into a visual analogueue scale, gaining patients perception of satisfaction/dissatisfaction with specified nurse caring behaviors. The instrument was renamed the CARE SATISFACTION QUESTIONNAIRE (CARE/ SAT) (Larson, 1993). To determined the theoretical adequacy, a factor analysis approach was used to examine the initial testing of the CARE/SAT. Additional items were developed and added by the author to meet psychometric requirements and to measure overall satisfaction with nurse caring behaviors reflective of contemporary domains of nurse caring behaviors. Ten of these items were generated to serve as a criterion measure for estimation of validity. The remainder were generated to tap heretofore unspecified components of the caring dimension.

To determine the adequacy of the CARE/SAT instrument's ability to assess patients' satisfaction with nursing care, a descriptive correlational study was undertaken. It involved 268 hospitalized adult medical surgical patients, within 48 hours of discharge from four hospital settings in the western United States, who were asked to respond to the CARE/SAT Questionnaire.

Factor analysis and the resulting theoretical recategorization resulted in a 29 item CARE/SAT categorized to three domains of nurse caring behaviors: assistive (12 items), benign neglect (11 items), and enabling (6 items). The CARE/SAT tool is a self-report scale of 29 items, divided into three subscales that measure patients' satisfaction with nurses' caring. The first subscale is called "Assistive". It is composed of 12 items and refers to basic nurse caring behaviors, such as explaining things and checking on the patient frequently. The second subscale is "Benign neglect". It consists of 11 items denoting noncarative nursing behavior. The last subscale is "Enabling" which has six items including nurse caring behaviors that assist patients to understand and actively

participate in their illness management (Appendix I contains details of this Factor Analysis). Individual items are summed to determine the total CARE/SAT with a possible range of 0 to 290, the higher score indicates satisfaction with experienced nurse caring behaviors. Mean CARE/SAT scores were skewed positively; that is, patients made the assessment that they were satisfied nurse caring behaviors.

Studies of Nurse Caring

Several nurse researchers have used the CARE-Q instrument in studies on nurses' caring. Mayer (1987) conducted a replication study of Larson's work, comparing oncology nurses' and patients' perceptions of nurse caring behaviors. Patients ranked highest: Knows how to give IVs, cheerful, encourages patient to call, puts patient first, anticipates "first time" as difficult. Nurses ranked highest: Listens, allows expression of feeling, patient knows self best, touches and perceptive of patients needs.

Keane, Chastain, & Rudisell (1987) conducted a similar study involving patients and nurses working in a rehabilitation setting. Patients' and nurses' five high mean score item were knows when to call the doctor, puts patient first, knows how to give shots and IVs, give medications on time and good physical care.

More recently, the CARE-Q has been used by faculty and students to explore nurse caring behaviors. Komorita, Doechring & Hirchert (1991) used the CARE-Q instrument to investigate the perceptions of caring by nurse educators. Listens to the patient was the most important caring behavior. The least important caring behavior was "is professional in appearance". Another study (Mangold, 1991), involved the perceptions of senior nursing students and professional nurses on nurse caring. Both groups agreed that the most important caring behavior was listens to the patient. Students identified "put patient first no matter what" as the least important behavior. Professional nurses ranked the least important behavior "is professional in appearance".

The Swedish version of the CARE-Q was used by von Essen and Sjoden (1991) to compare patients and staff perceptions of nurse caring behaviors in medical and surgical

specialties. Nurses ranked "Listens to the patient" as the most important nurse caring behavior. Patient ranked highest: knows when to call the doctor; knows how to give shots & IVs; is honest with the patient; puts the patient first; tells patient what is important.

According to the results of these studies, perceptions of caring appear to be influenced by the setting (rehabilitation vs. hospital care) in which the nurse-patient interactions occur and whether one is an enactor or a receipt of care. These studies indicate disagreement between professional nurses' perceptions of caring and patents perceptions of caring and may be due to variations in sample, design, or may indicate that perceptions of caring are indeed not congruent between caregiver and care recipient.

Patients rank instrumental behaviors higher, whereas nurses rank expressive behaviors as more important. Nurses in rehabilitation care (Keane, Chastain, & Rudisell, 1987) differ from other nurses in that they emphasize physical care before affective behaviors. According to Keane, Chastain, & Rudisell (1987), this ordering directly reflects rehabilitation nursing philosophy.

When hospitalized patients' perceptions of caring were examined with the CARE-Q and the Caring Assessment Behavior (CAB) Questionnaire (Cronin & Harrison, 1988), patients gave the highest ranking to caring items that depicted skill, knowledge, and judgment abilities of nurse (Cronin & Harrison, 1988; Keane, Chastain, & Rudisell, 1987; Larson, 1984a; Mayer, 1987; von Essen & Sjoden, 1991a). Studies that used a qualitative, open-ended questioning approach found that patients indicated that those involved with their care needed to be sensitive to their individuality and needed to be knowing and convey a sense of being to them (Brown, 1986; Larson, 1993a; Riemen, 1986; Swanson-Kauffman, 1988).

These studies did not address whether patients actually experienced the desired nurse caring from those who provided their care. For caring to have meaning, it must be perceived as being meaningful by both the enactor and the recipient (Davis, 1983; Gaut,

1984; Kovner, 1989). The importance of congruent perceptions of needs must be attended to if good caring is to be an achievable goal of nursing practice. Gardner and Wheeler (1979) state that if there exists a difference in the priorities placed by nurses and patients on various nursing activities, it may suggest a potential for poor communication and perhaps even discord between nurses and patients. Jennings and Muhlenkamp (1981) have found that nurses frequently misperceive emotional states like anxiety, depression and hostility in patients, thus supporting Gardner and Wheeler's (1979) findings; minimizing differences in how patients and nurses perceived behaviors may be important. Konver's (1989) results suggest that when patients and nurses agree on short term outcomes, patients have greater satisfaction.

Satisfaction Studies

The emphasis on patient satisfaction is consistent with the trend toward holding health professionals accountable to their consumers (Roberts & Tugwell 1987). McMillan et al.., (1986) suggest that the satisfaction factor may impact on whether the person seeks medical help, complies with the prescribed treatment and maintains a continuing relationship with a physician. Patient satisfaction surveys are undertaken for a variety of reasons and with a great variation in approach (Nelson & Niederberger, 1990). Some surveys assess patients' perceptions of all services, whereas others only address one aspect of patients' health care experience. Most surveys address patients' satisfaction with their nursing care.

Current nursing literature reflects the importance of nursing care systems that satisfy patients by meeting their individual needs from the patients' point of view (Spitzer, 1988). Larson has establish concurrent validity of the CARE/SAT with the Risser Patients' Satisfaction tool. The Risser Patient Satisfaction Questionnaire was originally designed to measure outpatient satisfaction with the nurse and nursing care (Risser, 1975). These data provide the link between nurse caring behaviors and satisfaction as an important dimension of nursing care in hospital patients. However, little is known about

satisfaction with nurse caring behaviors in ED patients. One study examined nurse caring in the ED (Huggins, Gandy & Kohut 1993). It did not however address the question of how satisfied patients in the ED are with nurse caring behaviors or how waiting time affect satisfaction.

Health care consumers do not like to wait for service. Patient satisfaction questionnaires received from ED patients include numerous complaints about waiting times (Smeltzer & Curtis, 1987b). Maitra (1992) conducted a patient satisfaction study in an urban accident and emergency department. Data showed that there was significant correlation between patient satisfaction and waiting time to see the doctor ($p < .05$). A study conducted to determine the relative importance of variables correlated with patient satisfaction with ED care and service (Bursch, Beezy & Shaw, 1993). Data showed that the most important variable associated with overall satisfaction with ED services was satisfaction with the amount time it took before the patient was cared for in the ED. These results demonstrate that the important concept is being "cared for" in a timely manner rather than simply being processed quickly through the ED. Their conclusion was further supported by data that showed that caring nurses were the next most important variable and a caring physician was the forth most important variable associated with overall satisfaction.

Krishel and Baraff (1993) explored the effect of ED information on patient satisfaction. They found patients who received ED information rated their overall satisfaction higher than did the control group ($p < .05$). Smeltzer and Curtis (1987b) demonstrated that although an average ED visit was 2.5 hours, less than 50% of patients were discharged within 2 hours of arrival, 35% had visits lasting 2 to 4 hours, and 16% stayed in the ED longer than 4 hours. Excessive ED waiting times may delay initiation of needed emergency care as well as cause frustration for patients.

Study Aims

The primary purpose of this study is to examine patients' satisfaction with nurse

caring behaviors in a large military hospital ED in Taiwan. The secondary purpose is to explore the relationship between satisfaction with nurse caring behaviors and waiting time in the ED.

Definition of Terms.

Caring is "intentional actions that convey physical care and emotional concern and promote a sense of safeness and security in another" (Larson, 1984).

Patient satisfaction implies an attitude which is based upon cognitive processes and is an antecedent of behavior (Shaw & Wright, 1967). Patient satisfaction with nursing care can be conceptualized as the degree of congruency between a patient's expectations of ideal nursing care and his perception of the real nursing care he received. Patients' satisfaction with nurse caring behaviors in this study is measured by patients responses to the CARE/SAT (Chinese version).

Triage means to classify based on patients severity of illness using preset criteria.

Triage categories III patients , defined in this study according the protocol of Tri-Service General hospital (TSGH), as patients who need to be seen within 30 minutes to receive treatment. This category includes cerebral vascular accident patients and overdose patients whose consciousness is clear.

Waiting time is the time interval between initially being seen by the triage nurse and being seen by doctor. Self-report waiting time was estimated by subjects. Chart-report waiting time was obtained from the permanent record. It was calculated by subtracting the time the patient presented to the nursing triage desk from the time the emergency department physician recorded seeing the patient.

The observation room is where patients who require certain types of intervention (e.g. intravenous antibiotics administered), or who need to be stabilized, but not necessarily hospitalized, are treated. It also serves to house patients when inpatient beds are not available. There are rooms for male, female, pediatric and gynecology patients that are located adjacent to the ED. Patients in the observation room may stay 5 days.

Methods

Sample and Setting.

This descriptive correlational study was conducted in Taipei, Taiwan, Republic of China. This hospital is a teaching hospital and medical center with 1500 licensed beds and emergency medical net with 54,000 visits to the emergency department in the last year.

For inclusion in the sample, patients had to meet the following criteria: (1) admitted to observation room at least 4 hours; (2) triaged class III and had a triage sheet attached to their medical record; (3) 18 years of age or older; (4) able to read Chinese; and (5) willing to complete the questionnaire. Because it was difficult to obtain data in the examination and treatment areas in the ED, patients were selected in the observation room. As triage category III patients comprised the majority of observation room patients, they were selected for study.

Instruments

Patients' satisfaction of nurses' caring was measured by the CARE/SAT (Chinese version) (Appendix II). This instrument is based on the CARE/SAT (Larson & Ferketich, 1993) and was modified, with authors' permission, by the researcher for use by Chinese patients in an ED setting.

The CARE/SAT (Chinese version) was designed to measure patients' satisfaction with nurse caring behaviors during their ED stay. In the CARE/SAT (Chinese version) 26 items from the CARE/SAT were used. Modification for the CARE/SAT (Chinese version) that were made to make it relevant to Chinese patients in the ED included: 1) three items not relevant to the ED were deleted: "Told me of support systems available to me, such as self-help groups"; "Provided me encouragement by identifying the positive aspects related to my condition and treatment"; and "Check with me as to the best time to talk about changes in my condition"; 2) three items were added "Told me how long it would be before I would see the doctor"; "Provided me emotional support"; and "Told me

what to do about changes in my condition"; 3) the order of the items was change to facilitate flow of reading and understanding by Chinese language readers. Face and content validity of the instrument were established.

The original CARE/SAT used a visual analogue scale where the patient marked an "X" on the 10-centimeter line adjacent to the item statement to indicate how much they agree or disagree. When the instrument was pilot tested with 11 Chinese participants, six of eleven felt that it was difficult to draw "X" on the line. The reasons were the line was too long to draw, not easy to understand and too abstract. To overcome these concerns, the researcher used a five-point likert-type scale instead of the visual analogue with the CARE/SAT (Chinese version) instrument.

Patients respond to each CARE/SAT (Chinese version) item by using of a five-point likert-type scale which asked them to rate "strongly disagree, disagree, no opinion, agree, strongly agree" adjacent to the item statement to indicate how much they agree or disagree that they experience that particular nurse caring behavior during their ED stay. To score the CARE/SAT, individual item responses (1 = strongly disagree, 2 = disagree, 3 = uncertain, 4 = agree, 5 = strongly agree) are summed to determine the total CARE/SAT (Chinese version) score (possible range: 29 to 145). The 12 negatively worded items are reverse scored. The scores in this study were calculated for each subscale as well as a total scores such that higher scores reflected patient satisfaction and lower score dissatisfaction, because it made sense to score scales in the direction such that higher scores indicated a greater amount of the trait that was measured.

A demographic sheet that included self-report waiting time was utilized. Demographic data were obtained by interview and from the chart. Items obtained by interview were age, sex, married status, education status, working status, military or civilian, and self -report waiting time. Items collected from the permanent record were chart-report waiting time, medical specialty, diagnosis, and chief complaint.

Procedures

This study was conducted within a specified 2-week time in 1995 in the ED of Tri-Service General Hospital. On arrival in the ED, patients were assessed by the triage nurse based on the hospital ED protocols and classified into one of four triage acuity groups (category I, II, II, IV). Within 4 hours of admission to the observation room in the ED, patients triaged as category III were approached and asked to participate in this study. Adult patients who met the sample criteria were given information about the study, were asked to participate, and informed consent was obtained.

The demographic data and the CARE/SAT (Chinese version) were self-administered by the subjects. Although the researcher was available to aid subjects who were experiencing difficulty answering the questionnaire, no attempts was made to interpret the items of the questionnaire to the subjects. Questionnaires were distributed to patients with as much privacy provided as possible and were collected after subjects were treated by the ED staff. The patient's chart was then reviewed for medical information by the researcher.

Results

The results of this study are presented in three parts: demographics, CARE/SAT (Chinese version) findings, and waiting time findings (Appendix III).

Sample Demographics

Of the 35 patients approached to participate in the study, 34 consented and 31 completed the questionnaire. One patient diagnosed with snake bite refused to participate. Three who consented did not complete the questionnaire. One could not read the questionnaire as she had not brought her reading glasses with her. A second could not understand the questionnaire and so stopped filling it out. The third was so tired that he fell asleep while completing the questionnaire.

The sample consisted 25 males and 6 females. The mean age was 28 years (SD = $\pm$ 9.94). Most of the patients were single (25/31) and one patient was separated. Most had high school education (15/31) while nearly half had complete some college

(13/31) and very few had less than a high school education(3/31). The majority of patients worked full time (26/31), three were unemployed, one worked part time and one was retired. The sample was evenly divided between military (15/31) and civilian persons (16/31). Sample demographic data are shown in Table 1.

The initial chief complaint, reason for admission to the observation room and major diagnosis of each person in the sample are shown in Table 2. Half of the patients stated pain was their major complaint. Patients represented many medical specialty including: general medicine (32.26%), general surgery (29.03%), ear-nose -throat (19.35%), orthopedics (16.13%) and dental (3.23%). They were generally admitted to the observation room for less than 4 days. Ten subjects were transferred from the outpatient building (OPD). One subject was transferred from another hospital. Six patients were admit to the observation room while waiting admission to the hospital.

CARE/SAT (Chinese version) Findings

The scores in this study were calculated so the higher CARE/SAT (Chinese version) total score and subscale score represented satisfaction and lower scores dissatisfaction with nurse's caring. The sample sizes for three subscales and CARE/SAT (Chinese version) total score differ because individuals could only obtain a subscale score if they answered 80% of the items for that subscale. The mean CARE/SAT (Chinese version) total score is 95.7 (SD = $\pm$ 12.3). The mean score of the Assistive subscale (12 items) is 41.4(SD = $\pm$ 6.4). The mean score of the Benign Neglect subscale (11 items) is 35.6 (SD = $\pm$ 4.4). The mean score of the Enabling subscale (6 items) is 18.7 (SD = $\pm$ 3.2). Table 3 shows the score for each subscales as well as total score.

The Assistive subscale, composed of 12 items, is shown in Table 4. Assistive subscale items were evaluated to determine the degree of satisfaction or dissatisfaction. The three items on which patients were most satisfied were item 3, "Encouraged me to call if I had any problems" (19/31); item 19, "Explained things important to my care" (19/31); and item 24, "The nurses were skilled when they gave me medications and/or

treatment " (21/31). The item on which patients most dissatisfied were item 17, "Volunteered to do little things, such as bringing me a cup of water, pillows, blankets, etc." (10/31). Nearly half of subjects checked the no opinion box on four items including item 8, "Knew when to call the doctor"; item 10, "Provided me emotional support"; item 15, "Gave me good physical care"; and item 20, "Checked on me frequently".

The Benign Neglect subscale, included 11 negatively worded items and was reverse scored (Table 5). The three items on which patients checked the disagree or strongly disagree box were item 21, "Did not give my medications or treatments as soon as possible" (16/31); item 22, "Were disorganized" (16/31); and item 26, "Were inconsistent in how they treated me" (17/30). The item on which patients were most dissatisfied item was item 18, "Did not know my need without me having to ask" (13/31). Three items were checked "no opinion" by half of the patients including item 7, "Appeared busy and could not provide me very much individual attention" (16/31); item 11, "Did not tell me how to take care of myself after I leave the emergency room" (15/29); and item 17, "Did not seem to treat me as an individual" (17/30).

In the six Enabling subscale items (Table 6), only the item 16, "Did not help me figure out questions for me to ask my doctor" is reverse scored. The item on which patients were most satisfied was item 29, "Help me to understand my disease and treatments" (19/31). The item on which patients were most dissatisfied was item 13, "Put me first, no matter what else happened" (11/31). Three items were checked "no opinion" by half of the patients including item 1, "Told me how long it would be before I would see the doctor" (17/31); item 12, "Anticipate my and my family concern about my diagnosis and planned opportunities to talk about it" (15/31); and item 13, "Put me first, no matter what else happened" (15/31).

Waiting Time

There were two measures of time in this study, self-report and chart-report waiting time. The mean self-report (n = 26) waiting time was 28.4 (SD = 36.3) minutes. The

mean chart-report (n = 26) waiting time was 23.4 (SD = 21.5) minutes. Five subjects records did not contain of the chart-report waiting time (subject 8, 9, 20, 25, 31). Most of them (80%) were ENT patients that had been sent to the ENT examination room on the second floor. There were six patients' chart-report waiting time over 30 minutes, which was the maximum time according the protocol of the hospital that triage category III patients can wait to be treated. Four out of six subjects were referred from the OPD.

There was no significant relationship between self-report waiting time and total CARE/SAT (Chinese version) score ($r = -0.17$, $p > .05$) nor was there a significant relationship between chart-report waiting time and total CARE/SAT (Chinese version) score ($r = -0.14$, $p > .05$) . To examine the relationship between self-report waiting time and chart-report waiting time, a Pearson Product Moment Correlation was calculated. Data show a positive, statistically significant correlation ($r = .43$, $p < .05$) between self-report waiting time and the chart-report waiting time. To explain whether patients' perceptions of waiting time were significantly different than actual waiting time measured with chart-render time, a paired t-test was performed. Data shown no significant difference ($t = .97$, $p > .05$) in perceived and actual waiting time (Table 7).

Discussion

The CARE/SAT (Chinese version) was purposely developed to assess perception of nurse caring behaviors of Chinese ED patients. This study's results indicate that for those concerned with the measurement of ED patients' satisfaction with nurse caring behaviors, the CARE/SAT (Chinese version) provides an efficient 29-item approach. ED patients were able to self-report their responds to the questionnaire.

In this study, patients were satisfied with more items on the Assistive subscale than on the other subscales. This may be because this subscale reflects basic nurse caring behaviors. Patients were satisfied with the physical care they received as shown by the high scores on multiple items (2, 3, 9, 19, 22, 23, & 24). The tendency of ED staff to generate satisfaction on physical rather than psychosocial care may reflect ED nursing

philosophy. According to data of many studies, perceptions of caring appear to be influenced by the setting. This is consistent with the findings of nurses in rehabilitation care (Keane et al., 1987) in that they emphasize physical care before affective behaviors. According to Keane et al.,(1987), this ordering directly reflects rehabilitation nursing philosophy. Patients rank instrumental behaviors higher, whereas nurses rank expressive behaviors as more important. (Mayer, 1986; Smit & Spoelstra,1991; Schart & Caley, 1993; von Essen & Sjoden, 1991). Cronin & Harrison (1987) offer an explanation for these findings in the form of Maslow's hierarchy of needs. There would seem to be a minimum care requirement that must be met before the more qualitative aspects of care, those traditionally valued by nurses, can be addressed. This is similarly reflected by Mayer (1987) who comments that patients may not be receptive to the expressive caring behaviors until basic physical need are met. Furthermore, Komorita et al., (1991) purport that compared to patients, nurses value the cognitive aspects of the process of caring. Patients cannot be expected to recognize and appreciate the knowledge nurses have in order to use these skills.

The emphasis of patients on the instrumental assistive activities may be due to the assumption that the more expressive behaviors are naturally present (McKenna, 1993). Hence, the expressive caring behaviors which are largely invisible are more noticeable when absent than present. In the study by Reiman (1986) on non-caring interactions, not once was an ill performed technical procedure mentioned as non-caring. Could it be that when absent, the affective elements become more important than the instrumental?

Perhaps there is considerable truth to the finding that patients are generally satisfied with their assistive nurse caring behaviors and this is appropriate for the ED where physical care is a primary patient need. In addition, in today's acute care setting, it is possible for nurses to enact the Assistive nurse caring behaviors without much extra effort.

It should be noted that not only physical nurse caring behaviors were satisfying to patients. They also found creating a sense of trust (item 9) and professional appearance

(item 23) as contributing to their satisfaction. For the enabling subscale, designed to address behaviors that assist patients to understand and actively participate in their illness management, helping patients to understand their disease and treatment (item 29) was also satisfying.

A possible explanation for the high level of satisfaction recorded by these subjects is that patients may be reluctant to express negative feelings about care providers, particularly if they expect to be dependent upon them in the future. Alternatively, patients at selected health care facilities supported by public funds may perceive the care they receive as a benefit and not want to appear ungrateful.

Some data suggest that patients may overestimate their satisfaction with care. This statement is supported by Heferin's (1979) study, which found that nurses underestimated expressed patient satisfaction with care. This study implied that nurse perceptions of patient satisfaction were accurate, and that patients (who may not have a valid basis for comparison) overestimate their own levels of satisfaction. It may be that the aspects of care that were found to be dissatisfying are more removed in time and memory and rated as less dissatisfying.

McMillan et al., (1986) point out that health care literature well documents the fact that consumers report satisfaction levels that are generally, if not always, biased toward the completely satisfied end of the scale. Therefore, after the initial glance, one must take the dissatisfaction of patients more seriously than might be thought. One third of patients were dissatisfied with three items from each of the CARE/SAT (Chinese version) subscales including item 17, "Volunteered to do little things, such as bringing me a cup of water, pillows, blankets, etc." (10/31) (assistive subscale); item 18, "Did not know my need without me having to ask" (13/31) (benign neglect subscale); item 13, "Put me first, no matter what else happened" (11/31) (enabling subscale).

On the Enabling subscale (Table 6) only item 29, "Help me to understand my disease and treatments" was ranked satisfying by 50% or more of the patients (19/31).

No other Enabling items were deemed satisfying by 50% of the respondents. Nurses are no doubt challenged in implementing enabling behaviors as they require nurses to spend time with patients to answer questions, provide important information, and work through issues associated with their disease and treatment. The ED may not be the appropriate setting where enabling type behaviors can or should be initiated by nurses.

One additional factor related to the sensitivity of the instruments may provide an alternative explanation. A great majority of the participants selected the "no opinion" category for many of the items. Six items were ranked "no opinion" by half of the patients. Three were from the Benign Neglect subscale including item 7, "Appeared busy and could not provide me very much individual attention" (16/31); item 11, "Did not tell me how to take care of myself after I leave the emergency room" (15/29); and item 17, "Did not seem to treat me as an individual" (17/30). The other three were from the Enabling subscale including item 1, "Told me how long it would be before I would see the doctor" (17/31); item 12, "Anticipate my and my family concern about my diagnosis and planned opportunities to talk about it" (15/31); and item 13, "Put me first, no matter what else happened" (15/31). Perhaps the CARE/SAT (Chinese version) tool was difficult to disagree with or most of the items on the tool were not sensitive enough to measure differences within the group of those well satisfied.

The Benign Neglect subscale, consistent of 11 negatively worded items. As noted in Table 5, two subjects selectively chose not to answer several items (items 4, 5, 6, 11, 14, 21, 26, 27). Both subjects did not answer item 11 (Did not tell me how to take care of myself after I leave the emergency room) because the instrument was administered before they were ready for discharge. In future studies, more control over the administration of the tool should be exercised. Further studies with a sufficiently large number of participants are needed to explore nurse caring behavior reflected in this subscale.

One concern is whether the CARE/SAT (Chinese version) subscales are sensitive

enough to determine the various ways that nurses convey caring to their patients. For example, although the patients in the study were relatively homogeneous on demographic valuables and level of acuity, there were distinct differences in how they perceived their nursing care. It is not clear whether patient assessment of a concept such as caring be equated with patient satisfaction. How patients determine satisfaction and dissatisfaction with nursing care needs further examination. The philosophical basis of a nursing unit and the interactive and/or the sequencing effect of identified important nurse caring behaviors are examples of areas that require additional research. Further, as Morse, Bottorff, Neander, and Solberg (1991) note, it is imperative that caring associated with nursing be connected to measurable outcomes.

Findings of this study can not be compared directly with those of Larson (1993) because of the difference in scaling. The original CARE/SAT used a visual analogue scale; the CARE/SAT (Chinese version) used a likert scale. Findings about the importance of physical nurse caring behaviors are not consistent between the Larson study (1993) and this study. It may be that there are difference related to patient perceived need that vary according to the setting or the population. Further testing is needed.

According the protocol of this study hospital, triage category III patients must be treated in less than 30 minutes. The mean chart-report waiting time (n = 26) was 23.4 (SD = 21.5) minutes. There were six subjects chart-report waiting time that was over 30 minutes ,which indicated that 20% of patients in the study did not met the standard of care dictated by triage category. Four out of six subjects waiting more than 30 minutes were referred from the OPD. This problem occurred even though the OPD attending physician informed the ED resident that the referring patient needed immediate medical attention. This raises concerns that some of the patients transferring from the OPD had to wait longer to obtain medical care which could jeopardized their health or welfare.

Long waiting times for OPD ambulatory patients result in a system of "rationing by queuing," in which the scarce resources of the emergency department are distributed on

the basis of triage. Overcrowding in the emergency department at Tri-Service General Hospital, Taipei, Taiwan, has become an increasing problem that has resulted from a shortage of beds in inpatient wards and intensive care units, transfers of National Health Insurance patients from other hospitals, and a growing demand of ambulatory patient for care in the ED. After implementation of the National Health Insurance Plan on 1995, there was a sharp increase in the number of patients admitted to the observation room due to shortage of beds in inpatient wards.

The mean self-report waiting time (n = 26) was 28.4 (SD = 36.3) minutes. Five subjects did not report their waiting time. The possible reasons were that they were too sick to notice, they did not pay attention, and it was too long to remember since they came into the ED. Because participants were enrolled in the study 4 hours after their admission to the observation room, administration time of the instrument varied somewhat from the time of admission to the ED. However, all responded within 96 hours. Further testing across setting with more stringent administration criteria will assist in determining the final discrimination.

Neither self-report waiting time nor chart-report waiting time had a significant relationship with CARE/SAT (Chinese version) total score ($r = -0.17$, $p > .05$.; $r = -0.14$, $p > .05$). A plausible explanation could be that the measurement was accurate but there were no differences; the other possible reason was the average waiting time (M= 23.4 minutes) in this study was shorter than that reported in other studies.

Nurses generally believe patients overestimate their waiting time in ED. In this study there were no significant differences ($t = .97$, $p > .05$) between patients' perceptions of waiting time and actual waiting time. Some studies have shown patients' self-assessments to be valid, reliable, and important reflections of individuals' health status (Buesching et al., 1985; Bindman et al., 1991).

LIMITATIONS

This study has several limitations. First, only triage category III patients who were

drawn from observation patients were included in this study. Thus, generalizability may be limited. In addition, although overcrowding and long waiting times are not unique to TSGH emergency department, the question of whether these findings can be applied to other sites cannot be answered without further investigation.

IMPLICATIONS

In this descriptive study, Larson's conceptualization of caring/patient satisfaction was used to address the ED patients' satisfaction with nurse caring behavior with a modified CARE/SAT (Chinese version). Nurses need to recognize and consider in their practice their patients' beliefs regarding important nurse caring behaviors. At times, cost containment pressures and limited resources cause nurses to make critical decisions about which task to complete and which to leave undone. In such an environment it is very important to know which activities make the patient feel best cared for. Further work will be needed on the of the CARE/SAT (Chinese version), especially continued administration to different categories of triage patients and across settings, to address the issue of validity. This study demonstrated that measurement of satisfaction with nurse caring behaviors is achievable as the CARE/SAT (Chinese version) is ready to be tested with other Chinese reading populations.

Faculty often emphasize the technical aspects of nurse caring behaviors. In previous studies (Komorita, Doehreng & Hirchert, 1991; Larson, 1984,1986, 1987; Mayer, 1987; Schart & Caley, 1993), the patient did not value the nontechnical activities as highly as they did technical activities. This suggests a need to educate faculty regarding these findings so that they can incorporate them into their teaching of nursing students.

Future study is needed in investigating the educational preparation of nurses in regard to the caring domains learned in the classroom and applied in the clinical setting: examining caring and patient satisfaction concepts at the baccalaureate and graduate levels; investigating the reaction of outpatients to caring when the caretakers are

registered nurses; and evaluating if the educational background of the nurse and the patient makes a difference in caring and satisfaction. These studies would be helpful because patients are very concerned about how much knowledge and skill they perceive the nurse to have or how confident they "feel" in the care they receive in the hospital from the nurse. It is not clear whether the academic preparation of the nurse (vocational, associate degree, or baccalaureate) makes a difference to the patients' perceptions of being cared for in the ED setting.

The care of ED patients is a team effort. If this teamwork is to be effective and collegial relationships between physicians and nurses are to be fostered, it is important to identify the perceptions and values of the team members and their patients. The ranking of important nurse caring behaviors by members of the team is a vital question. It remains unknown whether patients', physicians' and nurses ' perceptions are consistent. Replication of Larson 's studies (1984, 1986) with of CARE/SAT (Chinese version) could also help answer the question whether the agreement between nurses, patients, and physicians is observed in different care settings.

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Appendices

Appendix I

Factor analysis of CARE/SAT

Principal axes factoring with varimax rotation evolved a three-factor solution. For a factor to be considered, the eigenvalue had to be ≥ 1.00. A factor loading on each item of .50 with a spread of .20 for the loading was the criterion for a clean loading on a factor. Examination by the co-investigators and a panel of nursing experts of the nursing behaviors contained in the three-factor solution indicated that each factor was interpretable as an indication of the three characteristics of nursing caring behaviors.

Factor 1 Assistive, composed of 12 items, was the largest and had an eigenvalue of 10.09, accounting for 34.8% of the variance. This factor refers to basic nurse caring behaviors, such as explaining things and checking on the patient frequently. Among the 12 items of Factor 1 Assistive, 4 were from the Monitors and Follows through subscale of the CARE-Q, 3 were from the Accessible subscale, 2 each from the Comforts and Trusting Relationship subscales, and 1 from the Explains and Follows Through subscale.

Factor 2 Benign Neglect, denoting noncarative nursing behavior, consisted of 11 items, had an eigenvalue of 2.11, and accounted for 7.3% of the variance. Ten of the 11 items were negatively worded. Items representative this factor included not giving medication on time and being disorganized. Three items from each of the CARE-Q subscales Accessible, Trusting relationship, and Monitors and Follows Through and 1 item form Explains and Facilitates subscale were incorporated into this factor.

Factor 3 Enabling, had six items and had an eigenvalue of 1.40, accounting for 4.8% of the variance. This factor included nurse caring behaviors that assist patients to understand and actively participate in their illness management. Examples of these items are helping the patient to clarify thinking regarding the disease and treatment and putting the patient first no matter what happens. Factor 3 Enabling contained three items from the CARE-Q Trusting Relationship subscale, two from the Explains and Facilitates Subscale,

and one from the Anticipates subscale.

Three items that factor-loaded below .50 were included because of their relevance in the studies (Keane et al., 1987 Larson, 1984 a; Mayer, 1987; von Essen & Sjoden, 1991 a) that identified important nurse caring behavior: Knew how to give shots, I.V. s, and manage the equipment" from Factor 1 Assistive had a loading factor of .46; did not give a quick response to my call," which loaded at .40. and made me feel dumb by giving me inadequate information," which loading at .48 from Factor 2 Benign Neglect, were included because of their high ranking in the studies using the CARE-Q . For example, the item Knew how to give shots and IVs..." was ranked as either the most or second most important nurse caring behavior by the patients in several studies (Larson, 1984a; Mayer, 1987; von Essen & Sjoden, 1991a).

The results of the initial testing of the CARE/SAT study support the reliability and validity of the CARE/SAT questionnaire. This instrument, developed and refined in a series of research studies, provide a patient satisfaction measure that is based on the theoretical premise of caring at the behavioral level of nursing practice.

Appendix II

CARING SATISFACTION (CARE/SAT)

THE PURPOSE OF THIS QUESTIONNAIRE IS TO HAVE PATIENTS ASSESS THEIR NURSING CARE. YOUR IMPRESSIONS, ALONG WITH THOSE OF OTHER PATIENTS, WILL HELP NURSES IN DECIDING WAYS TO IMPROVE PATIENT CARE.

EACH STATEMENT REFERS TO A SPECIFIC NURSING ACTION. BASED ON YOUR EXPERIENCE, DECIDE HOW MUCH YOU AGREE OR DISAGREE WITH THE VIEW EXPRESSED. ON THE FIVE CATEGORIES OF AGREE-DISAGREEMENT TABLE NEXT TO THE STATEMENT PLACE AN "V" AT THE STATEMENT. THERE ARE NO RIGHT OR WRONG ANSWERS. YOUR RESPONSE IS A MATTRESS YOUR PERSONAL OPINION. YOUR INDIVIDUAL RESPONSE WILL NOT BE SHARED WITH ANYONE, ONLY GROUP DATA WILL BE REPORTED.

BELOW ARE EXAMPLES WHICH MAY HELP YOU IN RESPONDING TO THE QUESTIONNAIRE.

A. DURING MY EMERGENCY STAY THE NURSES IN THE DEPARTMENT.

	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
TAUGHT ME HOW TO TAKE MY MEDICINE.				V	

THE PLACEMENT OF AN "V" AT THE DISAGREE TABLE FOR QUESTION A IS A EXAMPLE OF A INDICATES THAT YOU DISAGREE THAT THE NURSES HAD TAUGHT YOU HOW TO TAKE YOUR MEDICINE.

B. DURING MY EMERGENCY ROOM STAY THE NURSES

	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
DID NOT GIVE MY MEDICINE AS SOON AS POSSIBLE.			V		

THE PLACEMENT OF THE AN "V" AT THE "NO OPINION" TABLE FOR QUESTION B IS A EXAMPLE OF WHERE YOU CANNOT QUITE DECIDE BECAUSE AT TIMES YOUR MEDICINE WAS AS SOON AS POSSIBLE AND AT OTHER TIMES IT WAS NOT.

PLACE AN "V" AT THE TABLE THAT BEST DESCRIBED YOUR OPINION WITH EACH STATEMENT.

DURING MY EMERGENCY DEPARTMENT STAY THE NURSES:

	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
1. TOLD ME HOW LONG IT WOULD BE FEFORE I WOULD SEE THE DOCTOR.					
2. PROVIDED BASIC COMFORT MEASURES, SUCH AS APPROPRIATE, POSITIONING, PILLOWS, BLANKETS, ETC.					
3. ENCOURAGED ME TO CALL IF I HAD ANY PROBLEMS.					
4. DID NOT GIVE A QUICK RESPONSE TO MY CALL.					
5. MADE ME FEEL DUMB BY GIVING ME INADEQUATE					
6. DID NOT WANT TO TALK ABOUT MY DISEASE/ INJURY AND TREATMENT.					

DURING MY EMERGENCY DEPARTMENT STAY THE NURSES:

	Strongly Disagree	Disagree	No opinion	Agree	Strongly Agree
7. APPEARED BUSY AND COULD PROVIDE ME VERY MUCH INDIVIDUAL ATTENTION.					
8. KNEW WHEN TO CALL THE DOCTOR.					
9. CREATED A SENSE OF TRUST FOR ME AND MY FAMILY.					
10. PROVIDED ME EMOTIONAL SUPPORT.					
11. DID NOT TELL ME HOW TO TAKE CARE OF MYSELF AFTER I LEAVE THE EMERGENCY ROOM.					
12. ANTICIPATED MY FAMILY'S AND MY CONCERN OVER MY DIAGNOSIS AND PLANNED OPPORTUNITIES TO TALK ABOUT IT.					
13. PUT ME FIRST, NO MATTER WHAT ELSE HAPPENED.					

DURING MY EMERGENCY DEPARTMENT STAY THE NURSES:

	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
21. DID NOT GIVE MY MEDICATIONS OR TREATMENT AS SOON AS POSSIBLE.					
22. ENCOURAGED ME TO ASK ANY QUESTIONS I MIGHT HAVE SUCH AS WHAT TO DO IF SYMPTOMS DO NOT IMPROVE OR BECOME WORSE.					
23. WERE PROFESSIONAL IN APPEARANCE.					
24. THE NURSES WERE SKILLED WHEN THEY GAVE ME MEDICATIONS AND/OR TREATMENT.					
25. WERE DISORGANIZED.					
26. WERE INCONSISTENT IN HOW THEY TREATED ME.					
27. DID NOT SEEM TO TREATMENT ME AS AN INDIVIDUAL					

DURING MY EMERGENCY DEPARTMENT STAY THE NURSES:

	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
14. DID NOT MAKE SURE OTHERS KNEW HOW TO CARE FOR ME.					
15. GAVE ME GOOD PHYSICAL CARE.					
16. DID NOT HELP ME FIGURE OUT QUESTIONS FOR ME TO ASK MY DOCTOR. SUCH AS FOLLOW-UP VISIT OR REEVALUATION.					
17. VOLUNTEERED TO DO "LITTLE" THINGS SUCH AS BRINGING ME A CUP OF WATER, EXTRA PILLOW, ETC.					
18. DID NOT KNOW MY NEEDS WITHOUT ME HAVING TO ASK.					
19. EXPLAINED THINGS IMPORTANT TO MY CARE.					
20. CHECKED ON ME FREQUENTLY.					

DURING MY EMERGENCY DEPARTMENT STAY THE NURSES:

	Strongly disagree	Disagree	No opinion	Agree	Strongly agree
28. TOLD ME WHAT TO DO ABOUT CHANGES IN MY CONDITION.					
29. HELPED ME TO UNDERSTAND MY DISEASE AND TREATMENT.					

Appendix III

Table 1. Sample Demographics

Variables	n	%
Age		
18-30	20	64.5
31-40	7	22.6
41-50	3	9.7
60-100	1	3.2
Gender		
M	25	80
F	6	.7
		19.3
Marital Status		
married	5	16.1
single	25	80.7
separate	1	3.2
Education		
junior high	3	9.7
high	15	48.3
2/5 yr. college	5	16.1
3 yr. college/4 yr. university	6	19.3
Gradual school	2	6.5
Working status		
full time	26	83.9
part time	1	3.2
retired	1	2.2
unemployed	3	9.7
Military		
military	15	48.4
citizen	16	51.6
Medical specialty		
General Medicine	10	32.2
General Surgery	9	29.0
Ear-Nose-Throat	5	16.1
Orthopedic	6	19.4
Dentist	1	3.2

Table 2. Chief Complaint, Reasons For Admission To Observation Room And Major Diagnosis Of Each Study Subject (n = 31).

ID	Subject	Chief complaint	Reasons of admission Observation Room	Major Diagnosis
1	GS	Epigastric pain and fullness	need observation	Intestinal obstruction
2	GS (ortho)	Fever, painful over left lower leg since 2 days ago	need observation	Acute osteomyelitis of left lower leg
3	ORT	Painful sensation over the pelvic region gait disturbance since 3 months ago	OPD transfer for inhospital admission	Acute Vascular Necrosis of left femoral head
4	GM (ortho)	Fracture femoral 20 days ago	OPD transfer for inhospital admission	Fracture of femur L/3
5	DEN	Trauma & bleeding over face	need observation	1. Lacerations over lip and nasal region 2. laceration wound of right knee
6	GS	Swelling painful sensation ,pus formation for 3 days	need observation	Cellulitis right hand
7	ENT	high fever for 4 days	need observation	Acute pharyngitis & tonsillitis
8	ENT	Sore throat & high fever for 4 days	need observation	Acute tonsillitis
9	ENT	Septal hematoma S/P SMP OPD	need observation	Septa hematoma S/P SMP
10	GM	high fever for 4 days	OPD transfer for observation	Urinary Tract Infection
11	GS	RLQ tenderness	OPD transfer for observation	Foreign body retention
12	ORT	Old Fracture of scaphoid	OPD transfer for inhospital admission	Old Fracture of scaphoid
13	GM (ENT)	Fever, SOB	need observation	Acute tonsillitis
14	GS	tenderness, painful sensation, erythmaitess of testitis	need observation	R/O Acute epididymitis
15	GM	diarrhea for one week, and periumbilical pain	need observation	R/O Acute appendicitis

16	GS	Pain swelling over right knee for 9 days	OPD transfer for observation	Anterior Cruciate ligaments rupture S/P reconstruction @ hemoarthrosis, R't knee
17	GM	Vomiting, abdomen pain	need observation	1. Acute gastroenteritis 2. Leukocytosis
18	GM	Epigastric, cramping pain with diarrhea	need observation	Acute gastroenteritis
19	GS	Painful sensation, tenderness over the L't femur	need observation	Cellulitis of left little toe
20	ENT	Fever, headache, sore throat ,cough	need observation	
21	ENT	Ear pain, palsy over left buccal region for 3 days.	need observation	Right Bell's palsy
22	ENT	Fever, throat	need observation	Acute tonsillitis
23	GS	Painful swelling over left foot about 1 month	need observation	1. Cellulitis left lower limb 2. Tinea left foot
24	ORTHO	Painful disability over left knee & right ankle Trauma	waiting for admission	Fracture of patella, left knee
25	GM	Fever, chills	need observation	Acute pyelonephritis left
26	GM	Bil upper limbs numbness and weakness	need observation	Hypokalemie paralysis
27	GS	Crushing injury Trauma	need observation	Crushing injury over the 2nd, 3 rd, 4th & 5th fingers of left hand with tendons exposure over fifth finger
28	GM	Passage of tarry stool two ago	OPD transfer for observation	Upper Gastrointestinal bleeding
29	GM	Watering diarrhea	need observation	Acute Upper Respiratory Infection with Upper Gastrointestinal upset
30	ORTHO	Painful swelling over Left ankle foot since 10 days ago	OPD transfer for inhospital admission	Calcareous Fracture, left
31	ORTHO	Painful disability over right hip since 11 months ago	Transfer from other hospital for admission	Fracture of femoral neck s/p op

Table 3 The Mean of CARE/SAT (Chinese Version) Total Score and Subscales Scores

Variable	n	possible of scores	Mean	SD
ASSERTIVE (12 items)	31	12 - 60	41.4	± 6.4
BENIGN NEGLECT (11 items)	29	11 - 55	35.6	± 4.4
ENABLING (6 items)	31	6 - 30	18.7	± 3.2
TOTAL	30	29 - 145	95.7	± 12.3

Table 4. Assistive Subscale

Assistive factors, composed of 12 items, refers to basic nurse caring behaviors, such as explaining things and checking on the patient frequently.

Items	Content	Direction of Scoring	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree	n	Proportion of patients were satisfied	Proportion of patient were dissatified
2	Provided basic comfort measures, such as appropriate positioning, pillows, blankets, etc.	+	0	4	10	12	5	31	17/31	4/31
3	Encouraged me to call if I had any problems.	+	0	2	10	12	7	31	19/31	2/31
8	Knew when to call the doctor.	+	0	5	14	12	0	31	12/31	5/31
9	Created a sense of trust for me and my family.	+	1	1	10	17	1	30	18/30	2/30
10	Provided me emotional support.	+	1	4	14	11	1	31	12/31	5/31
15	Gave me good physical care.	+	0	3	14	12	2	31	14/31	3/31
17	Volunteered to do "little" things, such as bringing me a cup of water, pillows, blankets, etc.	+	1	9	10	9	2	31	11/31	10/31
19	Explained things important to my care.	+	1	3	8	16	3	31	19/31	4/31
20	checked on me frequently.	+	0	4	14	11	2	31	13/31	4/31
22	Encouraged me to asked any questions I might have such as what to do if symptoms do not improve or become worse.	+	2	4	9	13	3	31	16/31	6/31
23	Were professional in appearance.	+	0	3	10	15	2	30	17/30	3/30
24	The nurses were skilled when they gave me medications and /or treatment.	+	0	1	9	18	3	31	21/31	1/31

Table 5. Benign Neglect Subscale

Benign Neglect factor, denoting noncarative nursing behavior, consisted of 11 items.

Items	Content	Direction of Scoring	Strongly Disagree	Disagree	No opinion	Agree	Strongly Agree	n	Proportion of patient were satisfied	Proportionof patient were dissatisfied
4	Did not give a quick reaponse to my call.	—	2	13	11	3	1	30	15/30	4/30
5	Made feel dumb by giving me inadequate information.	—	2	10	12	5	1	30	12/30	6/30
6	Did not want to talk about my disease/injury and treatment.	—	2	12	9	6	1	30	14/30	7/30
7	Appeared busy and could not provide me very much individual attention.	—	0	6	16	8	1	31	6/31	9/31
11	Did not tell me how to take care of myself after I leave the emergency room.	—	0	12	15	2	0	29	12/29	2/29
14	Did not make sure others know how to care for me.	—	0	11	12	7	0	30	11/30	7/30
18	Did not know my need without me having to ask.	—	0	6	12	11	2	31	6/31	13/31
21	Did not give my medications or treatments as soon as possible.	—	2	14	14	1	0	31	16/31	1/31
25	Were disorganized.	—	1	15	13	1	1	31	16/31	2/31
26	Were inconsistent in how they treated me.	—	3	14	13	0	0	30	17/30	0/30
27	Did not seem to treat me as an individual.	—	1	3	17	8	1	30	4/30	9/30

Table 6. Enabling Subscale

Enabling factor had six items included nurse caring behaviors that assist patients to understand and actively participate in their illness management.

Item	Content	Direction of Scoring	Strongly Disagree	Disagree	No opinion	Agree	Strongly Agree	n	Proportion of patient were satisfied	Proportionof patient were dissatisfied
1	Told me how long it would be before I would see the doctor.	+	2	4	17	7	1	31	8/31	6/31
12	Anticipated my and my family concern about my diagnosis and planned opportunities to talk about it.	+	1	5	15	9	1	31	10/31	6/31
13	Put me first, no matter what else happened.	+	0	11	15	5	0	31	5/31	11/31
16	Did not help me figure out questions for me to ask my doctor.	—	0	10	12	7	1	31	10/31	8/31
28	Told me what to do about changes in my condition.	+	0	6	12	12	0	30	12/30	6/30
29	Help me to understand my disease and treatments.	+	2	1	9	16	3	31	19/31	3/31

Table 7. Self-Report and Chart-Report Waiting Time*

Variable	n	Mean	S. D.
Self-report waiting time	22	31.50	38.44
Chart-report waiting time	22	24.23	22.61

* Pair t-test. $t = .97$, $p > .05$

For reference
Not to be taken from the room.

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